

U.S. Department of Labor

Office of Administrative Law Judges  
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DATE ISSUED: December 18, 2000

CASE NO.: 1999-BLA-214

In the Matter of

GARY RASNAKE,  
Claimant

v.

BBC COAL COMPANY,  
Employer

and

TRAVELERS INSURANCE COMPANY,  
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,  
Party-in-Interest

Appearances:

Mr. Ron Carson, Lay Representative,  
For the Claimant

H. Ashby Dickerson, Esq.,  
For the Employer & Carrier, Travelers

Before: RICHARD A. MORGAN  
Administrative Law Judge

**DECISION AND ORDER DENYING BENEFITS**

This proceeding arises from a duplicate claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.*, as amended (“Act”), filed on October 1, 1997. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,
3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis (“black lung disease” or “coal workers pneumoconiosis” “CWP”) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

### **PROCEDURAL HISTORY**

The claimant filed his first prior claim for benefits on December 11, 1995. (Director’s Exhibit (“DX”) 44.1). The claim was denied by the district director, on March 27, 1996, because the evidence failed to establish Mr. Rasnake was totally disabled due to pneumoconiosis. (DX 44.16). On June 21, 1996, the claimant requested a hearing. (DX 44.17). The district director did not forward the claim to the Office of Administrative Law Judges and the employer continued to submit exhibits. A correspondence from Mr. Carson referred to a September 4, 1996 denial, but evidence of that is not contained in the record. On December 3, 1996, the district director informed Mr. Carson the claimant had not filed any appeal of the director’s denial. (DX 44.37).

The claimant filed his most recent duplicate claim for benefits on October 1, 1997. (Director’s Exhibit (“DX”) 1). On February 5, 1998, the claim was approved by the district director. (DX 22). Interim benefits are being paid by the Trust Fund, as of October 1, 1997. (DX 46). On February 19, 1998, the employer controverted the award and requested a hearing before an administrative law judge. (DX 23). On November 16, 1998, the case was referred to the Office of Administrative Law Judges by the Director, Office of Workers’ Compensation Programs (OWCP) for a formal hearing. (DX 45). The case was initially set for a hearing on March 2, 1999, but continued several times because of the claimant and his representative. I was assigned the case on April 12, 2000.

On August 15, 2000, I held a hearing in Abingdon, Virginia, at which the claimant, employer, and insurer were represented.<sup>1</sup> No appearance was entered for the Director, Office of

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<sup>1</sup> Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner’s last coal mine employment is determinative of the circuit court’s jurisdiction. Under *Kopp v. Director, OWCP*, 877 F.2d 307, 309 (4th Cir. 1989), the area the miner was exposed to coal dust is determinative of the circuit court’s jurisdiction.

Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. Claimant's exhibits ("CX") 1-11, Director's exhibits ("DX") 1-46, and Employer's exhibits ("EX") 1- 39 were admitted into the record.

## **ISSUES<sup>2</sup>**

- I. Whether the miner has pneumoconiosis as defined by the Act and the Regulations?
- II. Whether the miner's pneumoconiosis arose out of his coal mine employment?
- III. Whether the miner is totally disabled?
- IV. Whether the miner's disability is due to pneumoconiosis?
- V. Whether there has been a material change in the claimant's condition?
- VI. Whether the miner has 13.8 years of coal mine employment?

## **FINDINGS OF FACT**

### *I. Background*

#### **A. Coal Miner<sup>3</sup>**

The parties agreed and I find the claimant was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations. He was a coal miner for at least 13.8 years. (Hearing Transcript (TR) 10; DX 1, 4, 5, and 44).

#### **B. Date of Filing**

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<sup>2</sup> In its post-hearing brief, the employer withdrew challenges to: timeliness; miner; and post-1969 coal mine employment. It agreed to 13.8 years of coal mine employment. The director erroneously listed modification as an issue.

<sup>3</sup> Subsection 718.301(a) provides that regular coal mine employment may be established on the basis of any evidence presented, including the testimony of a claimant or other witnesses and shall not be contingent upon a finding of a specific number of days of employment within a given period. The claimant bears the burden of establishing the length of coal mine employment. *Shelesky v. Director, OWCP*, 7 B.L.R. 1-34 (1984). Any reasonable method of computation, supported by substantial evidence, is sufficient to sustain a finding concerning the length of coal mine employment. *See Croucher v. Director, OWCP*, 20 B.L.R. 1-67, 1-72 (1996)(*en banc*); *Dawson v. Old Ben Coal Co.*, 11 B.L.R. 1-58, 1-60 (1988); *Vickery v. Director, OWCP*, 8 B.L.R. 1-430, 1-432 (1986); *Niccoli v. Director, OWCP*, 6 B.L.R. 1-910, 1-912 (1984).

The claimant filed his current claim for benefits, under the Act, on October 1, 1997. (DX 1). None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

C. Responsible Operator<sup>4</sup>

I find and the employer agrees that BBC COAL CORPORATION is the last employer for whom the claimant worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart F, Part 25 of the Regulations. (TR 6; DX 1, 2, 18, 44). According to Oleta Collins, BBC's bookkeeper, BBC entered Chapter 7 Bankruptcy in the mid-1990's. (DX 44-4). However, it was insured by Travelers.

D. Dependents

The claimant has no dependents for purposes of augmentation of benefits under the Act. (DX 1; TR 10).

E. Personal, Employment and Smoking History

The claimant was born on May 4, 1948. (DX 44). He is unmarried. (TR 10). He claimed to have worked in the coal mines from anywhere from ten to eighteen years. (DX 1; 44; TR 10). However, his testimony was uncertain. He had worked as a dozer operator for ten years which required him to stand eight hours, and lift and carry 100-pounds. (DX 3, 44). The claimant's last position in the coal mines was that of a mechanic who repaired equipment. (Hearing Transcript (TR) 10). This required him to stand, sit, or crawl eight hours and lift and carry 100-pounds frequently. (DX 44-3). He discontinued coal mining on June 1, 1993 because of a back injury. (DX 1; 44; TR 12).

The claimant, as part of his duties, was required to rebuild transmissions, perform heavy lifting of hydraulic pumps and drill bits, and be exposed to coal dust, all mostly above ground. (TR 11-12).

There is evidence of record that the claimant's respiratory disability may be due, in part, to his history of cigarette smoking. He admitted he began smoking at age twelve or thirteen. (TR 15). He claims to have quit smoking sometime after leaving coal mining and more than five years ago. (TR 16). His medical histories report varying levels of cigarette smoking. On January 25, 1994, Dr. Marshall reported a pack per day history. (DX 44-31). Dr. Corradino reported a five-year, pack per day, history. (DX 44.29). On January 29, 1996, Dr. Kanwal reported a pack per day, twenty-five year history ending three to four years earlier. (DX 44.11). On February 6, 1997, Dr. Sy recorded a 30-

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<sup>4</sup> 20 C.F.R. § 725.493 (a)(1) defines responsible operator as the claimant's last coal mine employer with whom he had the most recent cumulative employment of not less than one year.

year, pack per day history. (DX 12). On August 29, 1997, Dr. Paranthaman noted a two-pack per day smoking history for twenty years ending a year earlier. (DX 11.15). The miner reported a pack per day, ten year history to Dr. Forehand on October 27, 1997. (DX 10). On September 6, 1996, Dr. Sargent reported a history of smoking a pack on and off and not having smoked for three to four years. (DX 44). However, a contemporary carboxyhemoglobin test revealed an elevated level of 3%. (DX 44.29). On May 12, 1998, Dr. Castle reported the claimant began smoking at age 15 or 16 and stopping at forty-five, with several temporary cessations. (DX 32). In October 1998, Dr. Smiddy noted the miner stopped smoking in 1998.

Considering the above, I find the miner began smoking at about age twelve or thirteen and completely stopped in 1998 with several temporary intermediate cessations at a rate of a pack per day, thus yielding at least a 35 pack year history.

## *II. Medical Evidence*

The following is a summary of the evidence.

### A. Chest X-rays

There were some 72 readings of twenty-three x-rays, taken between June 25, 1991 and October 4, 1999. (Set forth in detail in Appendix A). The majority of the readings are properly classified for pneumoconiosis, pursuant to 20 C.F.R. § 718.102 (b).<sup>5</sup> Only six are positive, by physicians who are board-certified in radiology and/or B-readers.<sup>6</sup> Fifty-five are clearly negative by physicians who are either B-readers, board-certified in radiology, or both.<sup>7</sup> Thirteen, while not properly classified reveal chronic interstitial markings and changes, COPD, and diffuse chronic lung

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<sup>5</sup> ILO-UICC/Cincinnati Classification of Pneumoconiosis - The most widely used system for the classification and interpretation of x-rays for the disease pneumoconiosis. This classification scheme was originally devised by the International Labour Organization (ILO) in 1958 and refined by the International Union Against Cancer (UICQ) in 1964. The scheme identifies six categories of pneumoconiosis based on type, profusion, and extent of opacities in the lungs.

<sup>6</sup> *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. “A “B-reader” is a physician, often a radiologist, who has demonstrated proficiency in reading x-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. See 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to x-ray readings performed by “B-readers.” See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n. 2 (7th Cir. 1993).”

<sup>7</sup> *Cranor v. Peabody Coal Co.*, 21 B.L.R. 1-201, BRB No. 97-1668 (Oct. 29, 1999)(En banc). Judge did not err considering a physician’s x-ray interpretation “as positive for the existence of pneumoconiosis pursuant to Section 718.202(a)(1) without considering the doctor’s comment.” The doctor reported the category I pneumoconiosis found on x-ray was not CWP. The Board finds this comment “merely addresses the source of the diagnosed pneumoconiosis (under 20 C.F.R. § 718.203, causation).”

disease.<sup>8</sup>

## B. Pulmonary Function Studies

Pulmonary Function Tests are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV<sub>1</sub>) and maximum voluntary ventilation (MVV).

Physician Qual-ifications Date Exh.#	Age Height	FEV <sub>1</sub>	MVV	FVC	Tra-cings	Compre-hension Cooper-ation	Qualify* Conf-orm**	Dr.'s Impression
Banchuin 9/22/90 DX 44.26B	42 74"	2.98  3.21+		3.78  4.17+	yes	Good	No* Yes** No* Yes**	Castle finds valid with mild, clinically insignificant obstruction. (DX 32). Fino finds spirometry invalid. (EX 15).
Kanwal 1/29/96 DX 44.8	47 64"	1.89	60	1.92	Yes	Good Good	No*  No** Qualify-ing at 76".	Mild restriction. Castle finds invalid. (DX 32). Dr. Long finds invalid. (DX 44.27B). Rana-vaya finds invalid for poor effort. (DX 44.9). Fino finds invalid. (EX 15).

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<sup>8</sup> Chronic obstructive pulmonary disease (COPD) is the combination of emphysema and chronic obstructive bronchitis. THE MERCK MANUAL, 16th Edition (1992) at p. 659.

Physician Qualifications Date Exh.#	Age Height	FEV <sub>1</sub>	MVV	FVC	Tra- cings	Compre- hension Cooper- ation	Qualify* Conf- orm**	Dr.'s Impression
Sargent (BCI(P)) 9/4/96 DX 44.29C	48 76"	1.51 1.61+	35 20+	2.19 2.40+	Yes	Var- iable	Yes* No** Yes* No**	Castle finds invalid because lack of max exhalation & hesitation. (DX 32). Sargent notes miner was acutely ill, thus tests invalid. Fino finds invalid. (EX 15).
Sy (BC CC, EP) 2/14/97 DX 12.6	48 78"	1.77 1.54+	29	2.55 2.45+	Yes	Very poor	Yes* No** Yes* No**	Suggests restrictive lung defect. Dr. Stewart (BCI) finds invalid from submax-imal, inconsistent effort. (DX 25.2). Dr. Long finds invalid be-cause FVC curves not recorded at proper speed & volume dis-placement. (DX 26). Castle finds invalid be-cause lack of max ex-halation & hesitation. (DX 32). Fino finds invalid with no restric-tive defect. (DX 33, 36).
Sy 2/28/97 DX 12.7	48 78"	2.09		2.97	Yes		Yes* No**	Dr. Long finds invalid because of suboptimal effort. (DX 31). Castle finds abnormalities due to deconditioning & probable cardiac dysfunction. (DX 32).

Physician Qualifications Date Exh.#	Age Height	FEV <sub>1</sub>	MVV	FVC	Tra-cings	Compre-hension Cooper-ation	Qualify* Conf-orm**	Dr.'s Impression
Greenfield 10/17/97 DX 34.5	49 76"	2.15  2.31+		3.11  3.14+	Yes	Fair	Yes* Yes** Yes* Yes**	Dr. Emery finds acceptable test. (DX 34). Mild obstructive & moderate restrictive defect. Fino finds invalid. (EX 15).
Forehand (BCA, Ped) 10/27/97 DX 7, 13	49 74"	2.37  2.43+	62  57+	3.18  3.23+	yes	Good Good	Yes* Yes** Yes* Yes**	Obstructive ventilatory pattern. Reduced expir-atory volume & flow but volume curves not indicative of upper a/w obstruction. Abnormal p(A-a)O <sub>2</sub> gradients. Dr. Michos finds ac-ceptable but subopti-mal MVV perform-ance. (DX 8). Castle finds valid except MVV & no obstruc-tion. (DX 32). Fino finds invalid. (EX 15).

Physician Qualifications Date Exh.#	Age Height	FEV <sub>1</sub>	MVV	FVC	Tracings	Comprehension Cooperation	Qualify* Conf-orm**	Dr.'s Impression
Castle (BCI(P)) 5/5/98 DX 32.3; Dep. 21-23).	50 73"	2.58 2.58+	60 66+	3.34 3.34+	Yes	Good	No* Yes** No* Yes**	Castle finds MVV invalid cause of poor effort. No significant obstruction, restriction, or diffusion abnormal-ity. Very mild obstruction. Essentially, normal respiratory function. (Both results would be qualifying at 76"). Fino finds invalid. (EX 15).
Stone Mtn 12/14/98 CX 2	50 76"	1.64	28.5	2.73	Yes	Good Good	Yes* Yes?***	Severe obstruction with low vital capacity possibly from restrictive defect.
Craven (BCF) 11/30/99 CX 4	51 76"	1.87	37	2.49	Yes	Good Good	Yes* Yes**	Severe restriction. Fino finds invalid. (EX 38).
Craven (BCF) 6/21/00 CX 5	52 76"	2.57	41	3.48	Yes	Good Good	Yes* Yes**	Moderate restriction.

Heavy solid line indicates tests after denial of last claim. BCI(P)= board certified in internal medicine with subspecialty in pulmonary diseases. BCF= board certified in family practice. BCCC= board certified in critical care medicine. EP= board eligible pulmonary diseases.

\* A “**qualifying**” pulmonary study or arterial blood gas study yields values which are equal to or less than the applicable table values set forth in Appendices B and C of Part 718.

\*\* A study “**conforms**” if it complies with applicable quality standards (found in 20 C.F.R. § 718.103(b) and (c)). (*see Old Ben Coal Co. v. Battram*, 7 F.3d. 1273, 1276 (7th Cir. 1993)). A judge may infer, in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-1083 (1984). A study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

+Post-bronchodilator.

For a miner of the claimant's height of 76" inches, § 718.204(c)(1) requires an FEV<sub>1</sub> equal to or less than 2.66 for a male 52 years of age.<sup>9</sup> If such an FEV<sub>1</sub> is shown, there must be in addition, an FVC equal to or less than 3.35 or an MVV equal to or less than 106; or a ratio equal to or less than 55% when the results of the FEV<sub>1</sub> test are divided by the results of the FVC test. Qualifying values for other ages and heights are as depicted in the table below. The FEV<sub>1</sub>/FVC ratio requirement remains constant.

Height	Age	FEV <sub>1</sub>	FVC	MVV
74"	42	2.66		
76"	42	2.82		
64"	47	1.80	2.26	72
76"	47	2.74	3.43	110
76"	48	2.72	3.42	109
78"	48	2.88	3.61	115
74"	49	2.55	3.20	102
76"	49	2.71	3.40	108
Height	Age	FEV <sub>1</sub>	FVC	MVV
73"	50	2.47	3.11	99
76"	50	2.69	3.38	108
76"	51	2.67	3.36	107
76"	52	2.66	3.35	106

### C. Arterial Blood Gas Studies<sup>10</sup>

Blood gas studies are performed to detect an impairment in the process of alveolar gas

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<sup>9</sup> The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Associated Coal Co.*, 43 F.3d 3 (4th Cir. 1995). I find the miner is 76" here, the most often reported height.

<sup>10</sup> 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.

20 C.F.R. § 718.204(c) permits the use of such studies to establish "total disability." It provides: In the absence of contrary probative evidence, evidence which meets the standards of either paragraphs (c)(1), (2), (3), (4), or (5) of this section shall establish a miner's total disability: . . .

(2) Arterial blood gas tests show the values listed in Appendix C to this part . . .

exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O<sub>2</sub>) compared to carbon dioxide (CO<sub>2</sub>) in the blood indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Ex.#	Physician	pCO <sub>2</sub>	pO <sub>2</sub>	Qualify	Physician Impression
1/29/96 DX 44-9, 44.12	Kanwal	41.2 32.4+	75.2 94.0+	No No	Near normal. Fino finds normal. (EX 15).
9/4/96 DX 44.29D	Sargent	34	52	Yes	Abnormal AGS were due to acute pneumonitis. Fino finds hypoxia which can be caused by pneumonia. (EX 15).
11/7/96 EX 17	Kanwal	42.2	82.2	No	
2/14/97 DX 12.4	Sy	38.6	70	No	Mild hypoxia.
5/21/97 EX 16	Kanwal	41.1	72.1	No	Fino finds normal. (EX 39).
6/22/97 DX 11	Shukla	35.6	61.5	Yes	While hospitalized for bi-lateral pneumonia.
6/25/97 DX 11	Shukla	35.7	57	Yes	While hospitalized for bi-lateral pneumonia.
10/27/97 DX 13	Forehand	40 40+	57 79+	Yes No	Michos finds acceptable. (DX 8). Castle says pneumonia played a role in the PO <sub>2</sub> which improved in later tests. (Dep. 35). Fino says moderate hypoxia im-proved with exercise. (EX 15).
5/5/98 Dep. 24; DX 32.4	Castle	36.6	80.0	No	Entirely normal. Fino finds normal. (EX 15).
6/27/98 EX 27	Capalad	33.2	74.0	No	Fino finds normal. (EX 39).

Date Ex.#	Physician	pCO <sub>2</sub>	pO <sub>2</sub>	Qualify	Physician Impression
9/28/98 EX 14	Shukla	47.1	66.5	No	Fino finds this is only AGS showing minimal non-im-pairing hypoxia. (EX 39).
10/4/99 CX 8	Norton Hosp	40.5	102.6	No	Fino finds normal. (EX 39).

+ Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b).  
Heavy solid line indicates tests after denial of last claim.

#### D. CAT Scans

A CT scan of the chest was conducted on August 21, 1997, by Dr. Thomas Haines. (DX 11, 34). A 2-3 cm mass was discovered in the left lung such that a neoplasm could not be ruled out. Another CT, taken 10/17/97, was read by Dr. Cooper who opined it revealed emphysematous change in both lungs, an unchanged nodular lesion in the left mid-lung, and old calcified nodes.<sup>11</sup> (DX 11, 34). Dr. Scott believed the 2 cm mass was a probable calcified granuloma probably due to healed TB or histoplasmosis. (DX 27). Dr. Wheeler found it was probable healed granulomatous disease with no evidence of CWP or silicosis but could not rule out cancer. (DX 27).

#### E. Physicians' Reports

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(a)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(c)(1), (2), or (3), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. J. Randolph Forehand qualifications are not in the record.<sup>12</sup> His report, based upon his

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<sup>11</sup> "Emphysema" is defined as "a pathological accumulation of air in tissues or organs; applied especially to such a condition in the lungs (see pulmonary emphysema). DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, 28th Edition (1994), p. 545.

<sup>12</sup> I take judicial notice he is board certified in Pediatrics (1979) and Allergy/Immunology (1987).

examination of the claimant, on October 27, 1997, notes fifteen years of surface coal mine employment and a pack per day 10-year smoking history from 1985-1995. (DX 10). Dr. Forehand noted: the miner wears oxygen; has two-pillow orthopnea; has a daily productive cough; had hemoptysis previously with pneumonia; and experiences dyspnea for any activities.

Based on “qualifying” pre-exercise and “non-qualifying” exercise arterial blood gases showing hypoxemia, a “qualifying” pulmonary function study showing an obstructive abnormality, and a 10/27/97 chest X-ray showing interstitial changes which he read as “1/1”, Dr. Forehand diagnosed chronic bronchitis from smoking and interstitial lung disease questionably from coal dust exposure. (DX 10).

He opined that the claimant’s pulmonary condition was “more likely” related to his coal dust exposure, and cigarette consumption together. Dr. Forehand found the miner permanently and totally disabled with serious injury to his lungs. He opined the 10 years of smoking were unlikely to cause this all of the disability, although his time as a dozer operator were not particularly risky. However, the X-ray changes raise the possibility of occupational lung disease. (DX 10).

Dr. A. Sy examined the miner on February 6, 1997. (DX 11). He is board-certified in critical care medicine, board-eligible in pulmonary medicine and a diplomat of the American Board of Internal Medicine. He reported the miner complained of worsening shortness of breath for the past year. He noted he was being treated by Dr. McKnight for depression and Dr. Kanwal for chronic back pain. He noted he chewed tobacco for 10-15 years and smoked a pack per day

until two years ago. Dr. Sy’s impression was chronic bronchitis and CWP observing his 15-17 years of strip mine work. (DX 12). Cardiopulmonary exercise test results suggested inferior wall ischemia likely secondary to a reduced cardiac capacity for exercise. (DX 12). Dr. Sy believed Mr. Rasnake’s functional capacity (V)2 max) was moderately reduced, “compatible with mild functional impairment for an individual of this age and gender.” (DX 12).

Dr. Joseph F. Smiddy, who is board certified in internal medicine and board eligible in the subspecialty in pulmonary medicine, submitted a report, dated October 15, 1998. (CX 2). He reported an eighteen year coal mining history and that the miner stopped smoking in 1995. Based upon his review of a small number of records, examination, AGS, PFS, X-ray, and coal mining history, Dr. Smiddy diagnosed CWP from coal dust exposure confirmed by biopsy. (CX 2). He found the miner totally and permanently disabled based upon his need for oxygen and PFS abnormalities.

A one-page report of physical examination, dated 6/10/99, by Dr. Joseph Smiddy was submitted. (CX 9). He agreed with the radiologist’s X-ray report that there was no active process

with old nodular changes and scarring. The chest examination was clear. He diagnosed biopsy-proven CWP. The miner had presented to him in April 1999 with complaints of chronic dyspnea. He observed the miner utilized oxygen. He opined Mr. Rasnake is totally disabled. In November 1999, Dr. Smiddy saw X-ray films depicting old scarring, CWP, emphysema, and nodular changes.

Dr. Richard Naeye is board-certified in anatomic and clinical pathology and is extensively published. (DX 28). His report, dated March 12, 1998, notes 10-12 years of coal strip mine employment and a 20-40 pack-year smoking history. (DX 28). He reviewed enumerated records and reports and examined histologic slides. He observed not enough lung tissue was available to be certain CWP was absent, but since there was no fibrous tissue, no birefringent crystals, and no focal emphysema associated with the black pigment he saw, the minimal criteria for diagnosing CWP was absent.<sup>13</sup> Nor could he determine whether chronic bronchitis and bronchiolitis existed or not. He opined since none of the x-rays or clinical findings he reviewed showed CWP, CWP could not prevent him from returning to work. If the emphysema reported in X-ray readings is of the centrilobular type, it is not attributable to coal dust.<sup>14</sup> (DX 28).

Dr. James Castle is a B-reader and board-certified in internal medicine with a subspecialty in pulmonary medicine. His extremely comprehensive report, based upon his review of enumerated records and examination of the claimant, on May 5, 1998, notes a greater than 30-pack-year smoking history and a 16-year history of coal strip mine employment. (DX 32). He reported Mr. Rasnake has been on oxygen since July 1997. The doctor expressed familiarity with the miner's last coal mine job.

Based on examination, an EKG, a non-qualifying arterial blood gas study, a non-qualifying pulmonary function study, and a ("0/1") chest X-ray, Dr. Castle diagnosed: no CWP; history of pneumonia; possible mild, clinically insignificant airway obstruction; and, no significant respiratory impairment (DX 32). He explained the miner's significant smoking history was sufficient to have caused COPD, i.e., chronic bronchitis/emphysema, and/or lung cancer. He further explained Mr. Rasnake's overweight condition, lung scarring from pneumonia, and CAD contribute to his dyspnea upon exertion. Nor did Dr. Castle find evidence of a clinically significant interstitial pulmonary process expected with CWP. Moreover, he reported most X-ray readings were negative for CWP. His physiologic studies showed significant variability in effort and the fact they changed from qualifying to non-qualifying is further evidence against a CWP diagnosis. Finally, he opined that the claimant's pulmonary condition was not related to his coal dust exposure. (DX 32). While the miner may be

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<sup>13</sup> "Focal-dust emphysema" is defined as a form of pulmonary emphysema associated with inhalation of environmental dusts, producing dilatation of the terminal and respiratory bronchioles." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, 28th Edition (1994), p. 546.

<sup>14</sup> "Centriacinar or centrilobular emphysema" is defined as "focal dilatations of air spaces distributed throughout the lung in the midst of grossly normal lung tissue; the dilatations affect respiratory bronchioles rather than aveoli." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, 28th Edition (1994), p. 546.

disabled as a whole man, the disability is unrelated to coal mine employment or coal dust exposure, according to Dr. Castle. (DX 32). Mr. Rasnake's significant smoking history is enough to cause COPD, i.e., chronic bronchitis or emphysema or cancer. (Dep. 36).

Dr. Castle testified at a deposition, on October 20, 1998. (EX 13). At that time, he reiterated the substance of his earlier report. He explained the medical and legal definitions of CWP and that he referred to both when forming his conclusions. (Dep. 6). X-ray findings of CWP do not correlate with functional impairment. (Dep. 33). According to Dr. Castle, shortness of breath is subjective and is not necessarily a respiratory or pulmonary symptom. (Dep. 6-7). He testified the miner had a 25 pack-year smoking history. (Dep. 9). Mr. Rasnake's nonproductive cough did not support a chronic bronchitis diagnosis. (Dep. 10). Dr. Castle defined pneumonia. (Dep. 10-11). Lung scarring can, but not usually, result in some pneumonia patients which if sufficiently extensive can cause restriction on pulmonary function testing. (Dep. 12).

It was Dr. Castle's impression the miner's shortness of breath arose post-coal mining. (Dep. 14). He observed Mr. Rasnake used bronchodilators designed to treat reversible airways disease, i.e., asthma or tobacco-induced airway obstruction. CWP is not a reversible disease. (Dep. 14-15). He reported his 1998 examination showed an "essentially normal chest." (Dep. 17). He did not find Mr. Rasnake's use of oxygen justified based on PFS which showed essentially normal respiratory function. (Dep. 23). Dr. Castle explained the varied AGS results were not caused by anything permanent or irreversible. (Dep. 27). Some PFS results, i.e., 1996, are explained by his pneumonia. (Dep. 28). Dr. Forehand's 10/97 AGS result of fluctuating hypoxemia and normal response to exercise is explained by the miner's tobacco smoke-induced airway obstruction. (Dep. 28). Mr. Rasnake's AGS revealed hypoxemia related to ventilation perfusion mismatching, a transitory phenomenon most often related to people with underlying airways disease, particularly due to smoking. (Dep. 29-30). Dr. Castle concluded the miner does not suffer from CWP, legal or clinical, but does have a non-disabling smoking induced mild obstructive airways disease. (Dep. 30-31). He added that any further future respiratory deterioration would not be related to occupational exposure since five years post-coal mining he had none. (Dep. 32). Finally, even if the miner had positive chest X-rays, he nevertheless has no impairment related to coal dust exposure. (Dep. 34).

A medical report from Dr. Kanwal, dated 1/29/96, reflects a diagnosis of COPD, coal dust exposure and chronic back pain. He believed coal dust exposure was causing 10 percent or less disability, COPD 10-15 percent and chronic back pain 75-80 percent disability. (DX 44-11). Based upon an examination, the miner's work and medical history, a "1/0" X-ray, a PFS showing a mild restrictive defect, and a nearly normal AGS, Dr. Kanwal diagnosed: COPD; chronic back pains; and, coal dust exposure all due to his life long smoking and 18 years of coal dust exposure. (DX 44-11).

Dr. Dale Sargent, who is a B-reader and board certified in internal medicine with a subspecialty in pulmonary medicine, examined the miner and submitted a report, dated 9/4/96. (DX 44.29). He noted Mr. Rasnake's work and smoking history. Dr. Sargent noted the miner was acutely

ill the day of examination and thus his PFS was invalid and his abnormal AGS were due to acute pneumonitis. Thus, he was unable to determine to what extent the miner may have been impaired. (DX 44.29). Based on a positive (“1/1, q/q”) X-ray, he diagnosed simple CWP. (DX 44.29).

Dr. Gregory Fino, who is Board-certified in internal medicine with a subspecialty in pulmonary diseases, and is a B-reader, reviewed the claimant’s medical records on behalf of the employer and submitted his opinions in a report, dated February 8, 1999. (EX 15). His consultation report notes seventeen years of coal mine employment and a variably-reported lengthy smoking history. (EX 15). Dr. Fino concluded that the claimant did not have pneumoconiosis, but that he was disabled due to orthopaedic, psychiatric and possibly CAD problems. According to Dr. Fino, Mr. Rasnake has never given acceptable efforts on lung volumes and diffusing capacities and is not impaired from a respiratory standpoint. Any disability he may have were not due to coal mine dust exposure.

A supplementary letter from Dr. Fino, dated February 10, 1999, stated having reviewed Dr. Smiddy’s report and PFS of 10/15/98 and 12/14/98, did not change his opinion that Mr. Rasnake has no respiratory impairment, whether or not he has CWP. (EX 26). Dr. Fino submitted a supplementary report, dated July 19, 2000, wherein he reviewed additional enumerated information. (EX 39). He added the miner failed to give good effort on any PFS and there is no evidence of any type of oxygen transfer impairment that would disable him. (EX 39).

### *III. Hospital Records & Physician Office Notes*

The progress notes, 6/22/97-5/13/99, of Dr. A. T. Shukla and records of the miner’s lung biopsy at the Norton Community Hospital were submitted. (DX 11; CX 3). Mr. Rasnake was hospitalized for pneumonia in June 1997 from which he was recovering in August 1997. (DX 11). At various times throughout 1999, Dr. Shukla diagnosed bronchitis, exacerbation of COPD, and history of (benign) lung nodule. Post-hospitalization, Dr. Shukla noted his impression of COPD and recent pneumonia. (DX 11). Dr. Shukla’s progress notes do not assess the etiology of the COPD or bronchitis. A report from Dr. Paranthaman, dated August 29, 1997, expresses concerns of a neoplasm or pulmonary embolism. (DX 11). The miner was hospitalized from 9/5-9/9/97 again for pneumonia. (DX 11). The discharge diagnosis included COPD and a LUL mass. (DX 11).

On September 15, 1997, Dr. Tyler Greenfield examined the miner and wrote that he had COPD “presumably” attributable to smoking and black lung from mining. (DX 11). He observed the chronically ill patient was on portable oxygen. On November 6, 1997, Dr. Greenfield wrote that a chest CT, dated October 17, 1997, revealed a persistent nodular density in the periphery of the left mid-lung unchanged from a similar study in September 1997. A percutaneous needle biopsy was negative for carcinoma. (DX 11).

The record contains a series of office notes from Dr. Strang, a board-certified orthopedic surgeon who treated Mr. Rasnake for his back problems from 7/27/93 through 7/22/96. (DX 44-29). These reports show after his back sprain, he was limited, after 1994, to performing less than heavy labor. This apparently lead to depression. (DX 44-29). Dr. Marshall evaluated the miner for his back pain reporting he could only perform restricted duties. (DX 44-31). Dr. Wilson evaluated Mr. Rasnake for chronic headache and diagnosed post-concussion syndrome. (DX 44-32).

Dr. Corradino's medical records reflect Mr. Rasnake's back problems and difficulty with his lungs without reaching any diagnosis. (DX 44.29).

A series of medical documents from Norton Community Hospital were submitted many of which contain illegible handwriting. (DX 37). Those documents reflect Dr. Shukla's 1997-1998 opinion the miner suffered from pneumonia, CWP and COPD.

Dr. Banchuin's office notes, 8/30/90 to 4/28/94, reflect Mr. Rasnake's coal mining and medical history. (DX 44-26). He noted a history of COPD from 9/10/90, smoking 1 ½ pack per day, and renal insufficiency. On 9/22/90, he observed PFS showed mild restrictive disease improved post-bronchodilator and recommended the miner stop smoking. Again, in 1991 and 1992, when his COPD was exacerbated, Dr. Banchuin recommended Mr. Rasnake stop smoking. In 1994, Dr. Banchuin reported the miner continued to have shortness of breath, which he diagnosed as COPD. (DX 44-26).

Dr. McKnight treated Mr. Rasnake for depression. His office notes from 4/19/94-8/26/96, were submitted. (DX 44.29). He noted Mr. Rasnake walked with a cane. His diagnoses included: Major Affective Disorder and Anxiety Depressive Syndrome with Insomnia secondary to chronic pain. (DX 44.29). Dr. Paul Kelley, board-certified in psychiatry, treated the miner for major depression and anxiety. His reports are at DX 44-31.

Dr. Luciano D'Amato diagnosed benign breast disease, consistent with gynecomastia, on July 17, 1998. (EX 28).

#### *IV. Biopsy*

It appears the claimant had a limited fine needle biopsy of the left lung in September 1997 at the time he was diagnosed with pneumonia and having a 3 cm left lung mass. (DX 11.18, 11.20, 34). Dr. Paul Sides, a pathologist, reviewed the results and reported no evidence of malignancy, found possible granulomatous inflammation, and indicated a finding of scattered black particulate pigment thought to be both carbonaceous and anthracotic. (DX 11.21,11.22, 34). Dr. Richard Naeye reviewed the biopsy slides. In his March 12, 1998 report, he stated there was insufficient lung tissue to be sure whether CWP was present, but the tissue provided had no evidence of CWP. (DX 28.2).

## *V. Witness' Testimony*

Mr. Rasnake testified that he first noticed experiencing shortness of breath in 1987 or 1988. (TR 12). He saw Dr. Banshu, at the time, who prescribed inhalers. His shortness of breath is worse now than in September 1996. (TR 17). He presently utilizes oxygen around the clock and has done so for two to three years. (TR 13, 18). He also utilizes broncho-inhalers. He is unable to perform any activities outside the home mostly due to his breathing difficulties. (TR 13-14). He suffers shortness of breath and weakness upon exertion. (TR 17). He could no longer perform his last coal mine job duties because he could not walk a lot, crawl up and down the equipment or lift. (TR 14, 17). He is receiving Social Security disability benefits for his back and federal Black Lung Act benefits. (TR 14). He presently is treated by Dr. Shukla. (TR 15).

## *VI. Other*

On June 24, 1996, the Virginia Worker's Compensation Board denied Mr. Rasnake's claim for CWP primarily based upon the fact category "1" CWP could not be found on an X-ray submitted. (DX 24). In November 1994, Mr. Rasnake was awarded Social Security disability benefits for his depression with psychomotor retardation, insomnia, anxiety, and chronic pain. (DX 44-34).

An undated, half-page, letter from Dr. Shukla was submitted. (CX13). He wrote Mr. Rasnake has chronic shortness of breath, a respiratory impairment, with repeated admissions for exacerbation of COPD. The decrease in FEV1 and post vital capacity evidenced in a PFS are likely to result from occupational dust exposure, which could be coal dust as he is a retired miner. (CX 13).

## **FINDINGS OF FACT AND CONCLUSIONS OF LAW**

### **A. Entitlement to Benefits**

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and, *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). See *Lane v. Union Carbide Corp.*, 105 F.3d 166, 170 (4th Cir. 1997). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. See *Director, OWCP, v. Mangifest*, 826 F.2d 1318, 1320 (3d Cir. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986).

Since this is the claimant's second claim for benefits, he must initially show that there has been a

material change of conditions.<sup>15</sup>

To assess whether a material change in conditions is established, the Administrative Law Judge (“Administrative Law Judge”) must consider all of the new evidence, favorable and unfavorable, and determine whether the claimant has proven, at least one of the elements of entitlement previously adjudicated against him in the prior denial, i.e., disability due to the disease. *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996) (*en banc*) *rev’g* 57 F.3d 402 (4<sup>th</sup> Cir. 1995), *cert. den.* 117 S.Ct. 763 (1997); *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994); and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3d Cir. 1995).<sup>16</sup> *See Hobbs v. Clinchfield Coal Co.* 917 F.2d 790, 792 (4th Cir. 1990). If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Unlike the Sixth Circuit in *Sharondale*, the Fourth Circuit does not require consideration of the evidence in the prior claim to determine whether it “differ[s] qualitatively” from the new evidence. *Lisa Lee Mines*, 86 F.3d at 1363 n.11. The Administrative Law Judge must then consider whether all of the record evidence, including that submitted with the previous claim, supports a finding of entitlement to benefits. *See Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994) and *LaBelle Processing Co. v. Swarrow*, 72 F. 3d 308 (3rd Cir. 1995).

The claimant’s first application for benefits was denied because the evidence failed to show that: the claimant was totally disabled by pneumoconiosis. (DX 44-16). Under the *Sharondale/Lisa Lee Mines* standard, the claimant must show the existence of one of these elements by way of newly submitted medical evidence in order to show that a material change in condition has occurred. If he can show that a material change has occurred, then the entire record must be considered in determining whether he is entitled to benefits.<sup>17</sup>

Since I now find, as set forth below, that the claimant has established by means of PFS testing

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<sup>15</sup> Section 725.309(d) provides, in pertinent part:

In the case of a claimant who files more than one claim for benefits under this part, . . . [i]f the earlier miner’s claim has been finally denied, the later claim shall also be denied, on the grounds of the prior denial, unless the [Director] determines there has been a material change in conditions . . . (Emphasis added).

<sup>16</sup> *Allen v. Mead Corp.*, 22 B.L.R. 1-61 (2000). In Circuits which have not addressed the standard applicable to duplicate claims, under 20 C.F.R. 725.309, the Board overruled its position, in *Shupink v. LTV Steel Co.*, 17 B.L.R. 1-24 (1992), and adopts the position articulated in *Peabody Coal Co. v. Spese*, 117 F.3d 1001 (7<sup>th</sup> Cir. 1997)(*en banc*). That is, to establish a material change in conditions, a claimant must establish with evidence developed subsequent to the denial of the earlier claim that at least one of the elements of entitlement previously adjudicated against him or her.

<sup>17</sup> *Madden v. Gopher Mining Co.*, 21 B.L.R. 1-122, BRB No. 98-0714 BLA (Feb. 19, 1999). Lay testimony, standing alone, regarding the miner’s worsened condition, since the denial of his last claim, is insufficient to establish a material change of condition under 20 C.F.R. § 725.309, absent corroborating medical evidence.

that he suffers from a total respiratory disability, i.e., a material change of condition, I examine the entire record to determine whether benefits should be awarded.

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a “a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment.”<sup>18</sup> 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to “coal workers’ pneumoconiosis,” but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R. § 718.201. The term “arising out of coal mine employment” is defined as including “any chronic pulmonary disease resulting in respiratory or

pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.”<sup>19</sup> Thus, “pneumoconiosis”, as defined by the Act, has a much broader legal meaning than does the medical definition.

“ . . . [T]his broad definition ‘effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.’” *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4<sup>th</sup> Cir. 1990) at 2-78, 914 F.2d 35 (4<sup>th</sup> Cir. 1990) citing, *Rose v. Clinchfield Coal Co.*, 614 F. 2d 936, 938 (4<sup>th</sup> Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of

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<sup>18</sup> Pneumoconiosis is a progressive and irreversible disease; once present, it does not go away. *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 151 (1987); *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4<sup>th</sup> Cir. 1996)(*en banc*) at 1364; *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3<sup>d</sup> Cir. 1995) at 314-315. In *Henley v. Cowan and Co.*, 21 B.L.R. 1-148 (May 11, 1999), the Board holds that aggravation of a pulmonary condition by dust exposure in coal mine employment must be “significant and permanent” in order to qualify as CWP, under the Act.

<sup>19</sup> The definition of pneumoconiosis, in 20 C.F.R. section 718.201, does not contain a requirement that “coal dust specific diseases . . . attain the status of an “impairment” to be so classified. The definition is satisfied “whenever one of these diseases is present in the miner at a detectable level; whether or not the particular disease exists to such an extent as to become compensable is a separate question.” Moreover, the legal definition of pneumoconiosis “encompasses a wide variety of conditions; among those are diseases whose etiology is not the inhalation of coal dust, but whose respiratory and pulmonary symptomatology have nevertheless been made worse by coal dust exposure. See, e.g., *Warth*, 60 F.3d at 175.” *Clinchfield Coal v. Fuller*, 180 F.3d 622 (4<sup>th</sup> Cir. June 25, 1999) at 625.

pneumoconiosis if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995).

The Board has recently adopted the Director's position to hold that "a transient aggravation of a non-occupational pulmonary condition is insufficient to establish pneumoconiosis as defined at Section 718.201." *Henley v. Cowan and Co.*, 21 B.L.R. 1-148, BRB No. 98-1114 BLA (May 11, 1999).<sup>20</sup>

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest x-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106;<sup>21</sup> (3) application of the irrebuttable

presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.<sup>22</sup> 20 C.F.R. § 718.202(a).

In *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 2000 WL 524798 (4th Cir. 2000), the Fourth Circuit held that the administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from coal workers' pneumoconiosis. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, *i.e.* x-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In so holding, the court cited to the Third Circuit's decision in *Penn*

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<sup>20</sup> As a result, the Board concluded that the ALJ erred in finding legal pneumoconiosis based upon medical opinions which diagnosed a temporary worsening of pulmonary symptoms due to exposure to coal dust, but no permanent effect. *Id.*

<sup>21</sup> A negative biopsy is not conclusive evidence that the miner does not have pneumoconiosis, but positive results will constitute evidence of the presence of pneumoconiosis 20 C.F.R. § 718.106(c).

<sup>22</sup> In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel*, 21 B.L.R. 1-182 (1999) citing *Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B.L.R. 2-269 (4<sup>th</sup> Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), *i.e.*, the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

*Allegheny Coal Co. v. Williams*, 114 F.3d 22, 24-25 (3d Cir. 1997) which requires the same analysis.

The claimant has not established pneumoconiosis pursuant to subsection 718.202(a)(2) because the biopsy evidence in the record contains no evidence of CWP.<sup>23</sup> Rather, Dr. Sides, the reviewing pathologist, merely found scattered black particulate pigment and possible granulomatous disease.<sup>24</sup> While the tissue Dr. Naeye examined showed no CWP, he felt it was insufficient to rule out CWP through the histologic slides. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim filed after Jan. 1, 1982, with no evidence of complicated pneumoconiosis.

The CT scans likewise do not establish the existence of CWP. The CT readings suggest healed granulomatous disease from TB or histoplasmosis and emphysema or a possible neoplasm. The nodular lesion in the left lung was not shown to represent CWP. There is absolutely no suggestion the mass could represent complicated CWP. The most significant concern was that it could be cancerous.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence.<sup>25</sup> 20 C.F.R. § 718.202(a)(1). “[W]here two or more x-ray reports are in conflict, in evaluating such x-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such x-rays.” *Id.*; *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985).” (Emphasis added). (Fact one is board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 (1991) at 1-37. Readers who are board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n. 5 (1985).

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<sup>23</sup> The biopsy report substantially complies with the requirements set forth in § 718.106(a), in that it includes a detailed gross macroscopic and microscopic description of the visualized portion of the lung and a copy of the surgical notes and pathological report of the examination of the specimen. *Dagnan v. Black Diamond Coal Mining Co.*, 994 F.2d 1536, 1540 (11th Cir. 1993); *Dillon v. Peabody Coal Co.*, 11 B.L.R. 1-113 (1988).

<sup>24</sup> The regulations state that an autopsy finding “of anthracotic pigmentation, however, shall not be sufficient, by itself, to establish the existence of pneumoconiosis.” 20 C.F.R. § 718.202(a)(2). *Youghioghney & Ohio Coal Co. v. Pickana*, 1997 U.S. App. LEXIS 17208 at \*12, 117 F.3d 1421 (Table), 1997 WL 376958 (6th Cir. 1997). “Various cases have held that anthracotic nodules are sufficient evidence of pneumoconiosis. *Dagnan v. Black Diamond Coal Mining Co.*, 994 F.2d 1536, 1541-42 (11th Cir. 1993) (severe anthracosis); *Daugherty v. Dean Jones Coal Co.*, 895 F.2d 130, 132-33 (4th Cir. 1989) (anthracosis of hilar lymph nodes); *Lykins v. Director*, 819 F.2d 146, 147-148 (6th Cir. 1987) (failure to consider biopsy).” A showing of “nodular fibrosis” is not required. *Dagnan*, 994 F.2d at 1536.

<sup>25</sup> “There are twelve levels of profusion classification for the radiographic interpretation of simple pneumoconiosis. . . . See N. LeRoy Lapp, ‘A Lawyer’s Medical Guide to Black Lung Litigation,’ 83 W. VA. LAW REVIEW 721, 729-731 (1981).” Cited in *Lisa Lee Mines v. Director*, 86 F.3d 1358 (4th Cir. 1996) (*en banc*) at 1359, n. 1.

There were some 72 readings of twenty-three x-rays, taken between June 25, 1991 and October 4, 1999. (Appendix A). The majority of the readings are properly classified for pneumoconiosis, pursuant to 20 C.F.R. § 718.102 (b). Only six are positive, by physicians who are board-certified in radiology and/or B-readers. Fifty-five are clearly negative. Thirteen, while not properly classified reveal chronic interstitial markings and changes, COPD, and diffuse chronic lung disease. Nine readings reflect emphysema findings. Based upon the qualifications of the readers, the number of readings, and the accompanying comments, I can find only one of the twenty-three X-rays positive for CWP, i.e., that of 2/27/92, which was unchallenged. I find the X-ray evidence of 1/29/96 and 9/24/97 in equipoise. The remainder I find negative based upon the number of negative readings by readers who are B readers or board certified radiologists or dually qualified. A judge is not required to defer to the numerical superiority of x-ray evidence, although it is within his or her discretion to do so. *Wilt v. Woverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990). This is particularly so where the majority of negative readings are by the most qualified physicians. *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985); *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31, 1-37 (1991). Based upon the consistent and long history of negative X-rays, I do not find CWP established by X-ray evidence alone.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative x-ray. 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it.<sup>26</sup> *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

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<sup>26</sup> *Fields v. Director, OWCP*, 10 B.L.R. 1-19, 1-22 (1987). "A 'documented' (medical) report sets forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis. A report is 'reasoned' if the documentation supports the doctor's assessment of the miner's health. *Fuller v. Gibraltar Coal Corp.*, 6 B.L.R. 1-1291 (1984). . ."

In *Cornett v. Benham Coal, Inc.*, \_\_\_ F.3d \_\_\_, Case No. 99-3469 (6<sup>th</sup> Cir. Sept. 7, 2000), the Court held if a physician bases a finding of CWP only upon the miner's history of coal dust exposure and a positive X-ray, then the opinion should not count as a reasoned medical opinion, under 20 C.F.R. § 718.202(a)(4). (It also rejected Dr. Fino's opinion that the miner's affliction was due solely to smoking and not coal dust exposure because the PFS were not consistent with fibrosis, as would be expected in simple CWP. Fibrosis, while an element of medical CWP, is not a required element of legal CWP).

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Because of their various Board-certifications, B-reader status, and expertise, as noted above, I rank Drs. Castle, Sargent, and Fino equally as pulmonologists. Since Drs. Sy and Smiddy are only board-eligible in pulmonary medicine, I rank them somewhat below those who are board-certified. Since both Dr. Forehand and Naeye are board certified in their respective fields, I credit each of them. Since the qualifications of Drs. Kanwal, Greenfield, Strang, Sides, Banchuin, Paranthaman, Shukla, and Corradino are not in the record, I do not give as much weight to their opinions, based upon qualifications, as I do to the board certified physicians.

Drs. Shukla and Banchuin were Mr. Rasnake's treating physicians for three and one half and four years respectively. As such, generally their opinions would ordinarily be entitled to more weight as they are more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1989); *Jones v. Badger Coal Co.*, 21 B.L.A. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*)(Proper for judge to accord greater weight to treating physician over non-examining doctors).<sup>27</sup>

However, absent any showing of special expertise, I cannot for that reason alone give more credit to their opinions.

As a general rule, more weight is given to the most recent evidence because pneumoconiosis is a progressive and irreversible disease. *Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-166 (1983); and, *Call v. Director, OWCP*, 2 B.L.R. 1-146 (1979).<sup>28</sup> This rule is not to be mechanically applied to require that later evidence be

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<sup>27</sup> *Lango v. Director, OWCP*, 104 F.3d 573 (3d Cir. 1997). The Court wrote that while there is "some question about the extent of reliance to be given a treating physician's opinion when there is conflicting evidence, compare *Brown v. Rock Creek Mining Co.*, 996 F.2d 812, 816 (6th Cir. 1993)(opinions of treating physicians are clearly entitled to greater weight than those of non-treating physicians) with *Consolidation Coal Co. v. OWCP*, 54 F.3d 434, 438 (7th Cir. 1995)( improper to favor opinion of treating physician over opinions of non-treating physicians)," a judge may require "the treating physician to provide more than a conclusory statement (before finding pneumoconiosis contributed to the miner's death)."

*But see, Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 21 B.L.R. 2-269 (4<sup>th</sup> Cir. 1997), wherein the Court held that a rule of absolute deference to treating and examining physicians is contrary to its precedents. *See also, Amax Coal Co. v. Franklin*, 957 F.2d 355 (7th Cir. 1992) where the court criticized the administrative law judge's crediting of a treating general practitioner, with no apparent knowledge of CWP and no showing that his ability to observe the claimant over an extended time period was essential to understanding the disease, over an examining board-certified pulmonary specialist bordered on the irrational. The Court called judge's deference to the "treating physician" over a non-treating specialist unwarranted in light of decisions such as *Richardson v. Perales*, 402 U.S. 389, 91 S.Ct. 1420, 28 L.Ed.2d 842 (1971); *Garrison v. Heckler*, 765 F.2d 710, 713-15 (7th Cir. 1985); and, *DeFrancesco v. Bowen*, 867 F.2d 1040, 1043 (1989).

<sup>28</sup> *Cranor v. Peabody Coal Co.*, 21 B.L.R. 1-201, BRB No. 97-1668 (Oct. 29, 1999)(En banc). In a case arising in the Sixth Circuit, the Board held it was proper for the judge to give greater weight to more recent evidence, as the Circuit has found CWP to be a "progressive and degenerative disease." *See Woodward v. Director, OWCP*, 991 F.2d 314 (6<sup>th</sup> Cir. 1993) and

accepted over earlier evidence. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). The Fourth Circuit's rule is set forth in *Adkins v. Director, OWCP*, 958 F.2d 49, 16 B.L.R. 2-61 (4th Cir. 1992). There the Court held, it is rational to credit more recent evidence, solely on the basis of recency, only if it shows the miner's condition has progressed or worsened. The court reasoned that, because it is impossible to reconcile conflicting evidence based on its chronological order if the evidence shows that a miner's condition has improved, inasmuch as pneumoconiosis is a progressive disease and claimants cannot get better, "[e]ither the earlier or the later result must be wrong, and it is just as likely that the later evidence is faulty as the as the earlier. . ." See also, *Thorn v. Itmann Coal Co.*, 3 F.3d 713, 18 B.L.R. 2-16 (4th Cir. 1993). In the present case, the PFS establish a worsening respiratory disability.

In January 1996, Dr. Kanwal diagnosed COPD and "coal dust exposure." He determined coal dust exposure made a 10% contribution to the miner's disability and COPD 10-15%. Based upon his examination and a positive X-ray, Dr. Sargent diagnosed simple CWP on September 4, 1996. In February 1997, Dr. Sy diagnosed chronic bronchitis and CWP based on observing the miner's history of coal mine dust exposure. In September 1997, Dr. Greenfield diagnosed COPD from smoking and CWP from coal mine dust exposure. In October 1997, Dr. Forehand diagnosed chronic bronchitis from smoking and coal mine dust exposure and interstitial lung disease questionably from coal mine dust exposure. His smoking history was grossly incorrect. On October 15, 1998 and June 10, 1999, Dr. Smiddy diagnosed "biopsy proven" CWP from coal mine dust exposure. Between 1997 and 1999, Dr. Shukla often diagnosed COPD, CWP and bronchitis. In an undated letter, Dr. Shukla wrote, "[T]he decrease in FEV1 and post vital capacity evidenced in a PFS are likely to result from occupational dust exposure, which could be coal dust as he is a retired miner." (CX 13). In October 1997, Dr. Sides, a pathologist found evidence of anthracotic pigment in histologic slides. Finally, between 1990 and 1994, Dr. Banchuin frequently diagnosed COPD and shortness of breath. He found the non-qualifying 9/22/90 PFS to reveal a mild restrictive disease.

In March 1998, Dr. Naeye, a pathologist, determined the histologic slides showed no evidence of CWP, but were alone insufficient to be sure. On May 5, 1998 and in October 1998, Dr. Castle found no significant interstitial lung disease, but diagnosed CAD, COPD, emphysema and chronic bronchitis from smoking, and a mild, clinically insignificant airways disease from smoking. On February 8, 1999 and twice in 1999, Dr. Fino, finding no respiratory impairment, diagnosed CAD and no CWP.

The remaining physicians were concerned whether the mass in the miner's left lung was cancerous and other non-respiratory problems. Thirteen X-ray readings revealed chronic interstitial markings and changes, COPD, and diffuse chronic lung disease. Radiologists Haines and Baral found COPD without stating any etiology. Nine readings of Drs. Scott and Wheeler reflected emphysema findings without stating any etiology. Dr. Cooper's CT reading of 10/17/97 revealed emphysema,

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*Mullins Coal Co. of Virginia v. Director, OWCP*, 483 U.S. 135 (1987).

although Drs. Scott and Wheeler did not. Based upon his review of histologic slides, in March 1998, Dr. Naeye opined if the miner had centrilobular emphysema, it was not due to coal dust exposure. Dr. Castle opined the COPD, chronic bronchitis, and emphysema were secondary to smoking.

The explanations of Drs. Shukla and Greenfield for their determinations, are lacking. Dr. Shukla suggests the miner likely has an occupational dust disease but does not fully explain why. The miner clearly suffers from COPD, i.e., chronic bronchitis and emphysema. The etiology of the COPD is in dispute. The only physicians to address the etiology of the miner's emphysema, , i.e., Drs. Naeye and Castle, opined it is secondary to his smoking history. Dr. Kanwal was not clear as to the etiology of the COPD. Dr. Greenfield concluded with little or no explanation that the miner's COPD was secondary to smoking. He did not elucidate on the basis of his diagnosis and therefore I give it somewhat less weight. Dr. Babchuin found COPD but did not fully set forth his rationale. Dr. Castle found smoking was the source of the miner's COPD and airways obstruction. Dr. Sy diagnosed chronic bronchitis but did not explicitly relate it to coal mine dust exposure. Drs. Forehand diagnosed chronic bronchitis from both coal mining and smoking. Neither Dr. Smiddy nor Dr. Sargent diagnosed COPD! I give Dr. Forehand's opinion less weight because he grossly under assessed the smoking history. I discount Dr. Fino's opinion because he found no respiratory impairment contrary to most of the other physicians. I find therefore that the evidence does not establish the miner's COPD was due to coal mine dust exposure or CWP.

Dr. Smiddy was wrong in his determination that the biopsy revealed CWP. Dr. Sy's diagnosis of CWP was based on the work history and was not explicitly related to coal dust exposure. Dr. Sargent's CWP diagnosis was based upon an X-ray contrary to the vast majority of X-rays. Dr. Kanwal's "coal dust exposure" diagnosis is insufficient to constitute a CWP diagnosis. Drs. Greenfield's and Shukla's CWP diagnoses lack explanation. Drs. Forehand, Naeye, Castle, and Fino did not diagnose CWP. However, I discount Dr. Fino's opinion because he found no respiratory impairment contrary to most of the other physicians. Dr. Naeye could not totally rule out CWP because of insufficient tissue samples. Finally, I give more weight to the opinions of the board certified physicians than those physicians whose

credentials are unknown. Thus, as explained above, while it is somewhat possible the miner suffers from CWP, the physicians who concluded so either did not explain the bases for their opinions, explicitly or clearly link it to coal mine dust exposure or misinterpreted the biopsy results.

General disability determinations by a state or other agency, such as the state and Social Security Administration here, are not binding on the Department of Labor with regard to a claim filed under Part C, but the determination may be used as some evidence of disability or rejected as irrelevant at the discretion of the fact-finder. *Schegan v. Waste Management & Processors, Inc.*, 18 B.L.R. 1-41 (1994); *Miles v. Central Appalachian Coal Co.*, 7 B.L.R. 1-744 (1985); *Stanley v.*

*Eastern Associated Coal Corp.*, 6 B.L.R. 1-1157 (1984) (opinion by the West Virginia Occupational Pneumoconiosis Board of a “15% pulmonary functional impairment” is relevant to disability but not binding). *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988). Thus, I give the Social Security Administration and state determination some weight as to the existence of pneumoconiosis.

I find the claimant has not met his burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff’g sub. Nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

#### C. Cause of pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation’s coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).<sup>29</sup>

Since the miner had ten years or more of coal mine employment, the claimant would ordinarily receive the benefit of the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. However, in view of my finding that the existence of CWP has not been proven this issue is moot. Moreover, the presumption is rebutted by the medical opinion evidence discussed herein.

#### D. Existence of total disability due to pneumoconiosis

The claimant must show his total pulmonary disability is caused by pneumoconiosis. 20 C.F.R. § 718.204(b). Sections 718.204(c)(1) through (c)(5) set forth criteria to establish total disability: (1) pulmonary function studies with qualifying values; (2) blood gas studies with qualifying values; (3) evidence the miner has pneumoconiosis and suffers from cor pulmonale with right-sided congestive heart failure; (4) reasoned medical opinions concluding the miner’s respiratory or pulmonary condition

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<sup>29</sup> Specifically, the burden of proof is met under § 718.203(c) when “competent evidence establish[es] that his pneumoconiosis is significantly related to or substantially aggravated by the dust exposure of his coal mine employment.” *Shoup v. Director, OWCP*, 11 B.L.R. 1-110, 1-112 (1987).

prevents him from engaging in his usual coal mine employment; and (5) lay testimony.<sup>30</sup> Under this subsection, the Administrative Law Judge must consider all the evidence of record and determine whether the record contains “contrary probative evidence.” If it does, the Administrative Law Judge must assign this evidence appropriate weight and determine “whether it outweighs the evidence supportive of a finding of total respiratory disability.” *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *see also Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986), *aff’d on reconsideration en banc*, 9 B.L.R. 1-236 (1987).

Section 718.204(c)(3) is not applicable because there is no evidence that the claimant suffers from cor pulmonale with right-sided congestive heart failure. § 718.204(c)(5) is not applicable because it only applies to a survivor’s claim in the absence of medical evidence.

Section 718.204(c)(1) provides that a pulmonary function test may establish total disability if its values are equal to or less than those listed in Appendix B of Part 718. More weight may be accorded to the results of a recent ventilatory study over those of an earlier study. *Coleman v. Ramey Coal Co.*, 18 B.L.R. 1-9 (1993). The miner underwent eleven sets of PFS here between 9/22/1990 and 6/21/2000. Eight reported “qualifying” results; three did not. The first PFSs of 9/22/90 and 1/29/96 and the PFS of 5/5/98 did not report qualifying results. However, the 1/29/96 and 5/5/98 PFSs were qualifying had the correct height, i.e., 76 inches, been reported by Drs. Kanwal and Castle.

Dr. Fino, board certified in internal medicine with a subspecialty in pulmonary diseases, found all but three PFSs, i.e., 2/28/97, 12/14/98, 6/21/00, invalid based upon frequent legitimate concerns, e.g., lack of effort or non-reproducibility. Dr. Long, board certified in internal medicine, found the PFSs of 1/29/96, 2/14/97, and 2/28/97, invalid based upon frequent legitimate concerns, e.g., suboptimal effort. Dr. Castle, board certified in internal medicine with a subspecialty in pulmonary diseases, found the PFSs of 1/29/96, 9/4/96, 2/14/97, invalid based upon frequent legitimate concerns, e.g., hesitation or lack of effort. Dr. Ranavaya found the 1/29/96 PFS invalid for poor effort; the administering physician agreed the effort was very poor. Dr. Stewart found the 2/14/97 PFS invalid for submaximal, inconsistent effort. Dr. Castle found the 9/22/90 PFS valid. Dr. Emery found the PFS of 10/17/97 valid. Drs. Castle and Michos found the PFSs of 10/27/97 valid. Where multiple board certified pulmonologists have found a PFS invalid for legitimate reasons, I so find. As noted in the PFS chart, for the reasons expressed by the physicians finding those PFSs invalid, I find invalid the PFSs of 1/29/96, 9/4/96, 2/14/97, and 2/28/97. However, the PFSs from 10/17/97 through 6/21/00 are valid with “qualifying” results. The qualifying PFSs indicate the miner has a moderate to severe obstructive defect and a moderate to severe restrictive lung defect. Thus, total respiratory disability has been established by means of PFSs.

Claimants may also demonstrate total disability due to pneumoconiosis based on the results of

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<sup>30</sup> 20 C.F.R. § 718.204(c). In a living miner’s claim, lay testimony “is not sufficient, in and of itself, to establish disability.” *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994).

arterial blood gas studies that evidence an impairment in the transfer of oxygen and carbon dioxide between the lung alveoli and the blood stream. § 718.204(c)(2). Twelve sets of AGS were administered between 1/29/96 and 10/4/99. Eight had completely non-qualifying results. Three had completely qualifying results. The pre-exercise AGS of 10/27/97 was qualifying, but the post-exercise study was non-qualifying. All the AGS since 5/5/98 have been non-qualifying. The physicians say the results of the 9/4/96, 6/22/97, and 10/27/97, AGSs are not truly reflective of the miner's impairment since he suffered from pneumonia at the time of those AGSs. Given that more weight may be accorded to the results of a recent blood gas study over one which was conducted earlier (*Schretroma v. Director, OWCP*, 18 B.L.R. 1-17 (1993)), that some study results are inaccurate because the miner had pneumonia, and the fact all the most recent AGS are non-qualifying, I find the AGS alone do not establish total disability.

Finally, total disability may be demonstrated, under § 718.204(c)(1), if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b). Under this subsection, "... all the evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing the burden of establishing, by a preponderance of the evidence, the existence of this element." *Mazgaj v. Valley Camp Coal Company*, 9 B.L.R. 1-201 (1986) at 1-204. The fact finder must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993). Once it is demonstrated that the miner is unable to perform his usual coal mine work a *prima facie* finding of total disability is made and the burden of going forward with evidence to prove the claimant is able to perform gainful and comparable work falls upon the party opposing entitlement, as defined pursuant to 20 C.F.R. § 718.204(b)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). I consider the relative qualifications of the physicians as noted above.

I find that the miner's last coal mining position, i.e., mechanic, required heavy manual labor. Because the claimant's symptoms render him unable to walk much, crawl up and down the equipment or lift, I find he is incapable of performing the duties of his prior coal mine employment.

Only Drs. Forehand (1997) and Smiddy (1998, 1999) found the miner totally disabled from a respiratory standpoint. Dr. Forehand had a valid PFS from which to draw his conclusion. Likewise, Dr. Smiddy had valid PFS data from which to draw his conclusion. Drs. Naeye (1998) and Fino (2000), neither of whom examined the miner, found no respiratory disability. In 1997, Dr. Sy found only a mild functional impairment. Dr. Castle, in May 1998, found no significant respiratory impairment. In 1996, Dr. Kanwal found only partial respiratory disability with the miner's back problems accounting for most of his disability. Dr. Sargent ventured no opinion concerning disability. Dr. Strang found disability due to orthopedic problems. I discount Dr. Fino's opinion because he found

no respiratory impairment contrary to most of the other physicians. Since Dr. Castle is board certified in internal medicine with a subspecialty in pulmonary diseases, thus better qualified to render an opinion in this area than Drs. Smiddy or Forehand, I find total disability was not established through physician testimony through May 5, 1998. However, other than Dr. Fino's opinions which I have discounted, the PFSs conducted after the date of Dr. Castle's opinion, i.e., by Dr. Cravens, who is board certified in family practice medicine, are un rebutted and do establish total disability.

The Fourth Circuit rule is that "nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis." *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (4th Cir. 1994). In *Milburn Colliery Co. v. Director, OWCP*, [Hicks], 21 B.L.R. 2-323, 138 F.3d 524, Case No. 96-2438 (4th Cir. Mar. 6, 1998) citing *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994), the Court "rejected the argument that '[a] miner need only establish that he has a total disability, which may be due to pneumoconiosis in combination with nonrespiratory and nonpulmonary impairments.'" Even if it is determined that claimant suffers from a totally disabling respiratory condition, he "will not be eligible for benefits if he would have been totally disabled to the same degree because of his other health problems." *Id.* at 534.

The Benefits Review Board has likewise held that nonrespiratory and nonpulmonary impairments, such as the miner's orthopedic problems, psychological difficulties and CAD, are irrelevant to establishing total disability, under 20 C.F.R. § 718.204. *Beatty v. Danri Corp.*, 16 B.L.R. 1-1 (1991).

I find the claimant has met his burden of proof in establishing the existence of total disability. *Director, OWCP v. Greenwich Collieries [Ondecko]*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994), *aff'g sub. Nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3d Cir. 1993).

#### E. Cause of total disability<sup>31</sup>

The Board requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Scott v. Mason Coal Co.*, 14 B.L.R. 1-37 (1990)(*en banc*), *overruling Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988).

The Fourth Circuit Court of Appeals requires that pneumoconiosis be a "contributing cause" of

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<sup>31</sup> *Billings v. Harlan #4 Coal Co.*, \_\_\_ B.L.R. \_\_\_, BRB No. 94-3721 (June 19, 1997). The Board has held that the issues of total disability and causation are independent; therefore, administrative law judges need not reject a Doctor's opinion on causation simply because the doctor did not consider the claimant's respiratory impairment to be totally disabling.

the claimant's total disability.<sup>32</sup> *Toler v. Eastern Associated Coal Co.*, 43 F. 3d 109, 112 (4th Cir. 1995); *Jewel Smokeless Coal Corp. v. Street*, 42 F.3d 241, 243 (4th Cir. 1994). In *Street*, the Court emphasized the steps by which the cause of total disability may be determined by directing "the Administrative Law Judge [to] determine whether [the claimant] suffers from a respiratory or pulmonary impairment that is totally disabling and whether [the claimant's] pneumoconiosis contributes to this disability." *Street*, 42 F.3d 241 at 245.

"A claimant must be totally disabled due to pneumoconiosis and any other respiratory or pulmonary disease, not due to other non-respiratory or non-pulmonary ailments, in order to qualify for benefits." *Beatty v. Danri Corp. & Triangle Enterprises*, 16 B.L.R. 1-11 (1991) *aff'd* 49 F.3d 993 (3d Cir. 1995) *accord Jewell Smokeless Coal Corp.* (So, one whose disability is only 10% attributable to pneumoconiosis would be unable to recover benefits if his completely unrelated physical problems (i.e., stroke) created 90% of his total disability). The fact that a physician does not explain how he could distinguish between disability due to coal mining and cigarette smoking or refer to evidence which supports his total disability opinion, may make his opinion "unreasoned." *Gilliam v. G&O Coal Co.*, 7 B.L.R. 1-59 (1984).

There is evidence of record that claimant's respiratory disability is due, in part, to his undisputed history of cigarette smoking. However, to qualify for Black Lung benefits, the claimant need not prove that pneumoconiosis is the "sole" or "direct" cause of his respiratory disability, but rather that it has contributed to his disability. *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 914 F.2d 35, 14 B.L.R. 2-68 (4<sup>th</sup> Cir. 1990) at 2-76. *Jones v. Badger Coal Co.*, 21 B.L.R. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*). There is no requirement that doctors "specifically apportion the effects of the miner's smoking

and his dust exposure in coal mine employment upon the miner's condition." *Jones v. Badger Coal Co.*, 21 B.L.R. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*) *citing generally, Gorzalka v. Big Horn Coal Co.*, 16 B.L.R. 1-48 (1990).

If the claimant would have been disabled to the same degree and by the same time in his life had he never been a miner, then benefits cannot be awarded. *Hobbs v. Clinchfield Coal Co.*, 917 F.2d 790, 792 (4th Cir. 1990); *Robinson v. Pickands Mather & Co.*, 914 F.2d 35, 38 (4th Cir.

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<sup>32</sup> *Hobbs v. Clinchfield Coal Co.* 917 F.2d 790, 792 (4th Cir. 1990). Under *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 at 2-76, 914 F.2d 35 (4<sup>th</sup> Cir. 1990), the terms "due to," in the statute and regulations, means a "contributing cause," not "exclusively due to." In *Roberts v. West Virginia C.W.P. Fund & Director, OWCP*, 74 F.3d 1233 (1996 WL 13850)(4th Cir. 1996)(Unpublished), the Court stated, "So long as pneumoconiosis is a 'contributing' cause, it need not be a 'significant' or 'substantial' cause." *Id.*

1990).<sup>33</sup>

Only Drs. Forehand and Smiddy found the miner totally disabled. Dr. Smiddy's opinion implicitly finds CWP is the cause of the miner's disability. Dr. Forehand stated the disability was a result of the miner's occupational lung disease and smoking. However, his assessment of the miner's smoking habit was grossly wrong. Thus, I discount Dr. Forehand's opinion concerning the etiology of the disability. Dr. Smiddy's opinion was based on the erroneous premise CWP was "biopsy-proven." Thus, I discount his opinion as well.

Drs. Naeye (1998) and Fino (2000), neither of whom examined the miner, found no respiratory disability. In 1997, Dr. Sy found only a mild functional impairment. Dr. Castle, in May 1998, found no significant respiratory impairment. He found the source of the miner's respiratory ills to be his cigarette smoking. In 1996, Dr. Kanwal found only partial respiratory disability with the miner's back problems accounting for most of his disability. Dr. Sargent ventured no opinion concerning disability or causation. Dr. Strang found disability due to orthopedic problems. I discount Dr. Fino's opinion because he found no respiratory impairment contrary to most of the other physicians. Since Dr. Castle is board certified in internal medicine with a subspecialty in pulmonary diseases, thus better qualified to render an opinion in this area than Drs. Smiddy or Forehand, I find total disability was not established through physician testimony through May 5, 1998. While total respiratory disability is established by Dr. Craven's PFSs, she did not set forth the etiology.

The claimant has failed to prove that his total respiratory disability is due to coal worker's pneumoconiosis.

## CONCLUSIONS

In conclusion, the claimant has established that a material change in conditions has taken place since the previous denial, because he has now established a total respiratory disability. The claimant has not established he has pneumoconiosis, as defined by the Act and Regulations. The claimant has proven a total respiratory disability. He has not established his total respiratory disability is due to pneumoconiosis. He is therefore not entitled to benefits.

## ORDER

It is ordered that the claim of Gary Rasnake for benefits under the Black Lung Benefits Act is hereby DENIED.

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<sup>33</sup> "By adopting the 'necessary condition' analysis of the Seventh Circuit in *Robinson*, we addressed those claims . . . in which pneumoconiosis has played only a *de minimis* part. *Robinson*, 914 F.2d at 38, n. 5." *Dehue Coal Co. v. Ballard*, 65 F.3d 1189, 1195 n. 8 (4th Cir. 1995).

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RICHARD A. MORGAN  
Administrative Law Judge

RAM:dmr

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits review Board within 30 days from the date of this Order by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601**. A copy of a Notice of Appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, at the Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

APPENDIX A

<b>Exh. #</b>	<b>Dates: 1. x-ray 2. read</b>	<b>Reading Physician</b>	<b>Qualific- ations</b>	<b>Film Qual- ity</b>	<b>ILO Classif- ication</b>	<b>Interpretation or Impression</b>
DX 44.25	6/25/91	Navani	B; BCR			No significant abnormality.
DX 44.33E	6/25/91 10/14/96	Wiot	B; BCR	3	0/1, q/t, 1 LZ	Calcified granuloma LUL.
DX 44.33F	6/25/91 10/10/96	Spitz	B; BCR	2		Negative for CWP. Linear strands, calcifications LL, adhesion left cardiac border.
DX 44.35B	6/25/91 11/6/96	Wheeler	B; BCR	2		Negative for CWP or silicosis. Calcified granuloma LUL compatible with healed TB. Obesity.
DX 44.35C	6/25/91 11/6/96	Scott	B; BCR	2		Negative for CWP. Calcified granuloma LL. Hemidiaphragm elevation.
DX 44.25	2/27/92 11/27/95	Robinette	B; BCI(P)	2	2/1, q/t, 6 LZ	Pleural thickening.
DX 44.33B	6/15/92 10/21/96	Wiot	B; BCR	2		Negative for CWP. Calcified granuloma LUL. Non-occupational pleural scar.
DX 44.33C	6/15/92 10/14/96	Spitz	B; BCR	1		Negative for CWP. Calcified granuloma LUL vs noncalcified nodule. Linear strands LL.
DX 44.35D	6/15/92 11/6/96	Wheeler	B; BCR	2		Negative for CWP or silicosis. Calcified granuloma LUL compatible with healed TB. Atelectasis or scars.
DX 44.35E	6/15/92 11/6/96	Scott	B; BCR	1		Negative for CWP. Calcified granuloma LL. Hemidiaphragm elevation. Atelectasis or linear fibrosis LUL.

<b>Exh. #</b>	<b>Dates: 1. x-ray 2. read</b>	<b>Reading Physician</b>	<b>Qualific- ations</b>	<b>Film Qual- ity</b>	<b>ILO Classif- ication</b>	<b>Interpretation or Impression</b>
DX 16.2	6/22/93 10/10/96	Spitz	B; BCR	2		Negative for CWP. Calcification.
DX 44.33D	6/22/93 10/4/96	Wiot	B; BCR	1	0/1, q/t, 1 LZ	Post-inflammatory calcified granuloma LL.
DX 44.35F	6/22/93 11/6/96	Wheeler	B; BCR	2		Negative for CWP. Calcified granuloma LL compatible with healed TB. Atelectasis or scars with fibrosis compatible with healed inflammatory disease.
DX 44.35G	6/22/93 11/6/96	Scott	B; BCR	2		Negative for CWP. Calcified granuloma. Hemidiaphragm elev- ation. Atelectasis with pleural thickening or linear fibrosis.
DX 44.13	1/29/96 2/6/96	Navani	B; BCR	2	1/0, q/t, 6 LZ	LUL has old calcified granuloma. Chronic pleuro-parenchymal changes LML.
DX 44.15	1/29/96 3/13/96	Franke	B; BCR	1	1/0, t/t, 2 LZ	Thickened pleura LML from old infection. Calcified cm nodule LUL an old granuloma probab- ly from histoplasmosis.
DX 44.28B	1/29/96 9/9/96	Spitz	B; BCR	2		Negative for CWP. Linear strands & questionable pleural disease.
DX 44.28C	1/29/96 9/4/96	Wiot	B; BCR	2	0/1, q/t, 1 LZ	Calcified granuloma LUL. Scars.
EX 36	1/29/96 1/28/00	Wheeler	B; BCR	2		Negative for CWP. Cal- cified granuloma from healed TB. Scar compat- ible with healed pneu- monia.

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific- ations	Film Qual- ity	ILO Classif- ication	Interpretation or Impression
EX 37	1/29/96 1/29/00	Scott	B; BCR	2		Negative for CWP. Calcified granuloma. Hemidiaphragm elev- ation. Changes compat- ible with healed TB.
DX 44.29E	9/4/96	Sargent	B; BCI(P)	1	1/1, q/q, 6 LZ	No large opacities. Infiltrate in LUL could represent early pneumonia.
DX 44.33G	9/4/96 10/4/96	Wiot	B; BCR	3	0/1, q/t, 1 LZ	Calcified granuloma LL.
DX 44.33H	9/4/96 10/10/96	Spitz	B; BCR	1		Negative for CWP. Linear strands. Calcifications LL.
DX 44.35H	9/4/96 11/6/96	Wheeler	B; BCR	1		Negative for CWP or silicosis. Calcified granuloma LUL compat- ible with healed TB. Scars with fibrosis LML compatible with healed inflammatory disease. Check for emphysema.
DX 44.35I	9/4/96 11/6/96	Scott	B; BCR	1		Negative for CWP. Calcified granuloma LL. Minimal fibrosis &/or atelectasis LUL with pleural thickening. Hemi- diaphragm elevation.
EX 18	11/7/96 2/9/99	Wheeler	B; BCR	2		Negative for CWP. Cal- cified granuloma compat- ible with healed TB. Scar compatible with healed pneumonia. Emphysema.
EX 19	11/7/96 2/8/99	Scott	B; BCR	2		Negative for CWP. Calcified granuloma. Obesity. Scars probably due to healed infection.

<b>Exh. #</b>	<b>Dates: 1. x-ray 2. read</b>	<b>Reading Physician</b>	<b>Qualific- ations</b>	<b>Film Qual- ity</b>	<b>ILO Classif- ication</b>	<b>Interpretation or Impression</b>
DX 12.5	2/14/97	Gopalan				Prominent interstitial markings both lungs suspicious of pleural & parenchymal scarring in LT mid-lung; Nodular density LUL probably granuloma.
DX 38.5	2/14/97 6/29/98	Dahhan	B; BCI(P)	2		Negative for CWP.
DX 39.4	2/14/97 8/3/98	Scott	B; BCR	1		Negative for CWP. Calcified granuloma LUL. Obesity. Changes compatible with healed TB. Emphysema. Obesity.
DX 39.5	2/14/97 8/3/98	Wheeler	B; BCR	1		Negative for CWP or silicosis. Calcified granuloma compatible with healed TB. Scar or fibrosis compatible with healed pneumonia. Probable emphysema & obesity. Diaphragm elevation.
DX 37, 11.2	6/22/97	Baral	BCR			Pleural thickening and scarring. Interstitial changes bilaterally. Stranding & blunting probably related to COPD.
DX 39.8	6/22/97 7/30/98	Dahhan	B; BCI(P)	1		Negative for CWP. Nodule LUL. Granuloma?

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific- ations	Film Qual- ity	ILO Classif- ication	Interpretation or Impression
EX 1	6/22/97 9/6/98	Wheeler	B; BCR	1		Negative for CWP or silicosis. Calcified granuloma compatible with healed TB or histoplasmosis. Scars compatible with healed pneumonia. Linear & irregular fibrosis RLL or infiltrate. Possible atelectasis. Obesity.
EX 2	6/22/97 9/3/98	Scott	B; BCR	1		Negative for CWP. Probable hypoinflation. Cannot exclude acute pneumonia. Probable granulomata. Obesity. Changes compatible with healed TB. Obesity.
DX 37, 11.3	6/24/97	Baral				Linear opacities RLL.
DX 11.4, 34	7/21/97	Gopalan	BCR			Improvement, but still residual changes noted & could be chronic. Interstitial changes. 10x5 mm nodular density LUL likely a granuloma.
DX 39.6	7/21/97 7/30/98	Dahhan	B; BCI(P)	2		Negative for CWP. Nodule LUL, granuloma?
EX 3	7/21/97 9/6/98	Wheeler	B; BCR	2		Negative for CWP. Calcified granuloma LUL compatible with healed TB. Obesity. Diaphragm elevation. Scar & fibrosis compatible with healed pneumonia.
EX 4	7/21/97 9/3/98	Scott	B; BCR	1		Negative for CWP. Calcified granulomata & scar compatible with healed TB. Obesity.

<b>Exh. #</b>	<b>Dates: 1. x-ray 2. read</b>	<b>Reading Physician</b>	<b>Qualific- ations</b>	<b>Film Qual- ity</b>	<b>ILO Classif- ication</b>	<b>Interpretation or Impression</b>
DX 11.5, 34	7/28/97	Haines	BCR			Chronic interstitial changes in both lung fields. Linear & small nodular densities.
DX 39.7	7/28/97 7/30/98	Dahhan	B; BCI(P)	2		Negative for CWP. Nodule LUL, granuloma?
EX 5	7/28/97 9/6/98	Wheeler	B; BCR	1		Negative for CWP. Scar & fibrosis compatible with healed pneumonia. Calcified granuloma LUL compatible with healed TB. Diaphragm elevation. Obesity.
EX 6	7/28/97 9/3/98	Scott	B; BCR	1		Negative for CWP. Calcified granulomata & scar compatible with healed TB. Obesity.
DX 11.6, 34	8/21/97	Haines	BCR			No improvement in density LML. Chronic interstitial changes in rest of lung fields.
DX 11.9, 34	8/25/97	Haines	BCR			Chronic interstitial changes. Density persists.
DX 34, 11.10	9/5/97	Haines	BCR			Appears to be some atelectasis & infiltrate.
DX 34, 11.11	9/8/97	Haines	BCR			Chronic process in LL with acute process in RLL minimally changed from 9/5/97.
DX 27.2	9/8/97 3/24/98	Scott	B; BCR	1		Negative for CWP. Atelectasis or infiltrate. Pleural thickening compatible with healed infection. Calcified granulomata. Pneumonia.

<b>Exh. #</b>	<b>Dates: 1. x-ray 2. read</b>	<b>Reading Physician</b>	<b>Qualific- ations</b>	<b>Film Qual- ity</b>	<b>ILO Classif- ication</b>	<b>Interpretation or Impression</b>
DX 27.3	9/8/97 3/27/98	Wheeler	B; BCR	1		Negative for CWP or silicosis. Atelectasis or fibrosis compatible with healed inflammatory disease possible EM. Calcified granuloma compatible with healed TB or histoplasmosis. Obesity.
DX 38.4	9/8/97 6/29/98	Dahhan	B; BCI(P)	1		Negative for CWP. Infiltrate pneumonia?
DX 11.20, 34	9/24/97	Westerfield	B; BCR			PA expiratory view post-lung BX. Diffuse chronic LD & ill-defined mass in LL. Laterally pleural based. Negative for left pneumothorax.
DX 35.2	9/24/97 5/9/98	Wheeler	B; BCR	1		Negative for CWP. Inc lung markings w fibrosis. Scar & diaphragm elevation compatible with healed inflammatory disease. Calcified granuloma compatible with healed TB or histoplasmosis. Obesity. Mild hypoinflation.
DX 40.2	9/24/97 8/28/98	Fino	B; BCI(P)	1		Negative for CWP. Increased markings consistent with old inflammatory disease.
DX 14	10/27/97	Forehand	B	1	1/1, s/t, 4 LZ	Calcified granuloma LUL. Pleural scarring LMZ.
DX 15	10/27/97 11/14/97	Navani	B; BCR	3	1/1, q/t, 6 LZ	
DX 29.2	10/27/97 4/15/98	Scott	B; BCR	1		Negative for CWP. Scars. Atelectasis or fibrosis. Calcified granuloma.

<b>Exh. #</b>	<b>Dates: 1. x-ray 2. read</b>	<b>Reading Physician</b>	<b>Qualific- ations</b>	<b>Film Qual- ity</b>	<b>ILO Classif- ication</b>	<b>Interpretation or Impression</b>
DX 29.3	10/27/97 4/15/98	Wheeler	B; BCR	2		Negative for CWP. Fibro- sis compatible with heal- ed pneumonia. Calcified granuloma compatible with healed TB. Obesity.
DX 35.3	10/27/97 5/28/98	Fino	B; BCI(P)	1		Negative for CWP. Increased markings w/scarring consistent with old inflammatory disease.
EX 11	11/6/97 1/27/99	Dahhan	B; BCI(P)	2		Co.
EX 7	11/6/97 1/13/99	Wheeler	B; BCR	1		Negative for CWP. Linear fibrosis MLL compatible with healed pneumonia. Calcified granuloma LUL compatible with healed TB. Hyperinflation with increased markings & increased AP diameter chest compatible with EM. Scars. Atelectasis.
EX 8	11/6/97 1/12/99	Scott	B; BCR	1		Negative for CWP. Cal- cified granulomata LUL. Scars RUL. Changes compatible with healed TB. Obesity.
DX 27.4	1/26/98 3/24/98	Scott	B; BCR	2		Negative for CWP. Obes- ity. Calcified granuloma, scar, thickened pleura.
DX 27.5	1/26/98 3/27/98	Wheeler	B; BCR	2		Negative for CWP or silicosis. Obesity. Calci- fied granuloma due to with healed TB.
EX 8.3, DX 38	1/26/98 6/29/98	Dahhan	B; BCI(P)	2		Negative.
DX 37.2	2/5/98 6/19/98	Ahmed	B; BCR	1	2/2, t/q, 6 LZ	

<b>Exh. #</b>	<b>Dates: 1. x-ray 2. read</b>	<b>Reading Physician</b>	<b>Qualific- ations</b>	<b>Film Qual- ity</b>	<b>ILO Classif- ication</b>	<b>Interpretation or Impression</b>
EX 10	2/5/98 1/12/99	Scott	B; BCR	1		Negative for CWP. Obesity. Calcified granuloma LUL compat-ible with healed TB.
EX 12	2/5/98 1/27/99	Dahhan	B; BCI(P)	2		Negative. co.
EX 9	2/5/98 1/13/99	Wheeler	B; BCR	2		Negative for CWP. Scars with fibrosis compatible with healed pneumonia. Calcified granulomata & scars due to with healed TB. Atelectasis or scar RML. Emphysema with increased AP diameter chest & decreased mark-ings. Obesity.
DX 32.5; Dep. 18	5/5/98 5/8/98	Castle	B; BCP	2	0/1, s/t	No CWP. The increased irregular opacities in the lower LZ most likely related to smoking & inflammatory disease Hx. Scars likely from prior pneumonia.
DX 38.2	5/5/98 6/29/98	Dahhan	B; BCI(P)	2		Negative.
DX 39.2	5/5/98 8/3/98	Scott	B; BCR	1		Negative for CWP. Obesity. Calcified gran-uloma LUL due to with healed TB. Emphysema.
DX 39.3	5/5/98 8/3/98	Wheeler	B; BCR	2		Negative for CWP or silicosis. Scars with fibrosis compatible with healed pneumonia. Cal-cified granulomata due to healed TB. Obesity.

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualific- ations	Film Qual- ity	ILO Classif- ication	Interpretation or Impression
EX 20	6/27/98 2/9/99	Wheeler	B; BCR	1		Negative for CWP. Scars with fibrosis compatible with healed pneumonia. Calcified granulomata due to healed TB. Emphysema with decreased markings. Obesity.
EX 21	6/27/98 2/8/99	Scott	B; BCR	1		Negative for CWP. Obesity. Calcified granuloma & scars compatible with healed TB.
EX 23	7/23/98 2/8/99	Scott	B; BCR	1		Negative for CWP. Obesity. Calcified granuloma & scars due to with healed TB.
EX 22	7/23/98 2/9/99	Wheeler	B; BCR	1		Negative for CWP. Scars with fibrosis compatible with healed pneumonia. Calcified granulomata compatible with healed TB. Emphysema with decreased markings. Obesity.
EX 24	7/31/98 2/9/99	Wheeler	B; BCR	2		Negative for CWP. Scars with fibrosis compatible with healed pneumonia. Calcified granulomata compatible with healed TB. Probable emphysema with decreased markings. Obesity.
EX 25	7/31/98 2/8/99	Scott	B; BCR	2		Negative for CWP. Obesity. Calcified granulomata LUL & scars compatible with healed TB.
EX 29	5/13/99 8/13/99	Dahhan	B; BCI(P)	1		Negative for CWP. Granuloma LUL.
EX 30	5/13/99 8/26/99	Wheeler	B; BCR	1		Negative for CWP. Scars compatible with healed pneumonia. Calcified granulomata compatible with healed TB. Obesity.

Exh. #	Dates: 1. x-ray 2. read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation or Impression
EX 31	5/13/99 8/24/99	Scott	B; BCR	1		Negative for CWP. Obesity. Calcified granuloma. Changes compatible with healed TB.
CX 8	10/4/99	Haines	BCR			Chronic COPD, Chr interstitial changes both lungs, chr scarring LUL
EX 33	10/4/99 12/30/99	Wheeler	B; BCR	2		Negative for CWP. Scar and calcified granulomata compatible with healed TB or possible healed histoplasmosis. Obesity.
EX 33	10/4/99 12/29/99	Scott	B; BCR	2		Negative for CWP. Obesity. Calcified granulomata & scar compatible with healed TB.
EX 35	10/4/99 1/18/00	Fino	B; BCI(P)	1		Negative for CWP. Markings & thickening consistent with old inflammatory disease.

\* A- A-reader; B- B-reader; BCR- board-certified radiologist; BCP-board-certified pulmonologist; BCI= board-certified internal medicine; BCI(P)= board-certified internal medicine with pulmonary medicine sub-specialty; BCF=board-certified family practice. Readers who are board-certified radiologists and/ or B-readers are classified as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 N.16, 98 L.Ed. 2d 450 (1987) and, *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists.

\*\* The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp.*, 6 B.L.R. 1-307 (1983)(Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997))(en banc)(Unpublished). If no categories are chosen, in box 2B(c) of the x-ray form, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.